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ADMINISTRATIVE SERVICE AGREEMENT

This Agreement is between Family Golf Centers, Inc. and Anthem Health & Life Insurance Company of New York (hereinafter "Anthem Health of NY") effective 01/01/98.

SECTION 1 EFFECTIVE DATE AND TERM

This Agreement shall be effective as of 01/01/98 to 01/01/99 and shall continue in full force and effect for successive yearly terms until terminated as provided herein.

SECTION 2 BASIS OF THIS AGREEMENT

The Sponsor has adopted a self-funded accident and sickness plan (Plan) for certain of its employees and their eligible dependents. This Plan is described in the Sponsor's Plan Document and Employee Booklet(s) which will be attached to and made a part of this Agreement. The Sponsor has selected Anthem Health of NY to perform certain of the administrative functions of the Plan and Anthem Health of NY desires to perform such functions. A description of these functions is made a part of the Agreement as Exhibit A.

SECTION 3 CLAIMS PAYMENT PROCEDURES

Subject to Anthem Health's right to receive reimbursement from the Sponsor, Anthem Health of NY will process all claims submitted under the Plan. Anthem Health of NY will process and pay benefits in accordance with the Plan and its policies and procedures and will incorporate sound business practices and be responsible for reasonable audits, reviews and investigations.

Anthem Health of NY contracts directly or through third party vendors to provide networks of medical care providers who have agreed to provide a form of managed care. The cost of accessing these contracts varies. For example, when Anthem Health of NY contracts directly, the cost is either a percentage of the fee reduction (i.e., 25%) or a fee per employee (capitated rate) and the arrangements with third party vendors are similar. Where the cost is directly attributable to a particular claim that cost is processed as a claim for benefits under the Plan. Where the cost is a capitated rate that cost is included in the SECTION 4 SERVICE FEE. Some of Anthem Health's contracts with providers allow discounts, allowances, incentives, adjustments and settlements not directly attributed to a particular claim or not determined at the time the claim is processed. These amounts are for the sole benefit of Anthem Health of NY and Anthem Health of NY will retain any payments resulting there from. All claims submitted will have claims, copayments and deductibles calculated without regard to the discounts, allowance, incentives, etc.

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In New York State, Plans contribute to the funding of Indigent Medical Care and Graduate Medical Education through surcharges added to payments for enumerated services and assessments payable to the Department of Health. These payments will be processed as a claim for benefits under the plan.

Anthem Health of NY will provide to the Sponsor a monthly bill for checks issued that are the liability of the Sponsor and a report describing such payments. Anthem Health of NY may advance funds to pay such claims and will charge the Sponsor for such funds it advances the Sponsor to pay such claims. All amounts for which the Sponsor is liable are due within 10 days after the date Anthem Health of NY bills the Sponsor.

Anthem Health, at its option, may require the Sponsor to advance the equivalent of 45 days of estimated claims by either a letter of credit or cash in one lump sum. The security will be due within 15 days of the date we tell you the amount required. Anthem Health of NY will pay simple annual interest (as declared from time to time) by Anthem Health of NY on any lump sum cash deposit.

SECTION 4 SERVICE FEES

The Sponsor agrees to pay Anthem Health of NY a service fee, described below, as reasonable compensation for the Administrative functions Anthem Health of NY performs.

The Service Fee or Monthly Fixed Cost for each month will be the sum of the number of units in each class multiplied by the applicable Monthly Fixed Cost Factor.

Anthem Health of NY will allow a 31 day grace period for payment of each Monthly Fixed Cost due after the first. During this period this Agreement will remain in force, unless it ends during this period as set forth in SECTION 19, TERMINATION OF AGREEMENT. If the Monthly Fixed Cost is unpaid at the end of the grace period, this Agreement will automatically terminate. Upon such termination, the Sponsor will be liable for any unpaid Monthly Fixed Cost.

Anthem Health of NY shall have the right to change, from time to time, the Monthly Fixed Cost Factors. Any such change will become effective (a) not less than 31 days after the mailing of written notice of such change to the Sponsor, or the Sponsor's designated agent, and (b) not before each plan anniversary, except as described below.

Anthem Health of NY shall have the right to change the Monthly Fixed Cost Factors in the event any of the following occurs: (a) a change in the benefits provided by the Plan; (b) a reduction in lives below 25 covered employees in any plan month; (c) a change in the number of covered employees or dependents of more than 25 percent from one plan month to the next; (d) a change in the number of covered employees or dependents of more than 10 percent per month over any three (3) plan months in a row.

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Anthem Health of NY may change the Monthly Fixed Cost Factors as of the effective date of any of the above occurrences, no matter when notice of the occurrence of the event is provided.

SECTION 5 COMPENSATION TO AGENTS OR BROKERS

Sponsor acknowledges that Anthem Health of NY may pay reasonable compensation to the agent or broker of record. He or she is not a trustee of the plan, a plan administrator (within the meaning of ERISA Sec. 3(16)(a) and Sec. 414(g) of the Internal Revenue Code), a named fiduciary of the plan (within the meaning of ERISA Sec. 402(a)(2)), or a fiduciary who is expressly authorized in writing to manage, acquire, or dispose of the assets of the above plan on a discretionary basis. Such compensation shall be based on a % variable scale.

SECTION 6 ENROLLMENT AND DETERMINATION OF ELIGIBILITY

a. The Sponsor shall:

- Handle all routine inquiries from employees, including inquiries from employees seeking information concerning enrollment in the Plan and inquiries from Plan participants seeking information concerning particular aspects of the Plan.
- Handle all enrollment activity and inquiries at its own expense.
- Notify employees and Plan participants of their right to apply for benefits and make available the necessary claim forms supplied by Anthem Health.
- Notify employees and the participants of their conversion rights, if any.

- b. In determining any person's right to benefits under the Plan, Anthem Health of NY shall rely on eligibility information consistent with the description in the Plan Document and Employee booklet or with submission of the claim. It is mutually understood that the effective performance of this Agreement by Anthem Health of NY will require that it be advised on a timely basis by the Sponsor of the identity of persons covered under the Plan, and the effective date or the termination date of their coverage.

The Sponsor shall also furnish to Anthem Health of NY such other information as may reasonably be required for the proper administration of the Plan.

It is mutually agreed that Anthem Health of NY shall not be responsible for delay in the performance of its duties under this Agreement or for the non-performance of its duties under this Agreement, which delay or non-performance is caused or contributed to by the failure of the Sponsor to furnish any such information.

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SECTION 7 RESCISSIONS

Anthem Health, as part of the services it provides the Sponsor, evaluates the health information provided by Employees and Plan participants on enrollment forms and/or health statements in its assessment of the risk to the Plan. In the event that a Plan Participant materially misrepresents information on such forms and statements, Anthem Health of NY will determine whether such person's coverage(s) should be rescinded.

If Anthem Health of NY determines coverage(s) should be rescinded, Anthem Health of NY will continue to pay claims at the direction of the Sponsor. The Sponsor agrees that in no event will such claims be included under the Specific and Aggregate Stop Loss Limits of the Stop Loss Policy issued by Anthem Health of NY to the Sponsor.

For the purposes of excluding such claims under the Stop Loss Policy, Anthem Health of NY in its sole discretion reserves the right to determine what constitutes a material misrepresentation. Such determination will be in accordance with its standards for its own insurance business.

If it determines that the coverage(s) should be rescinded, it will inform the Sponsor that the coverage(s) will be rescinded under the Stop Loss Policy.

SECTION 8 COVERED EMPLOYEE RECORDS

The Sponsor will keep a record of the covered employees and Plan participants. This record will contain all of the data that is specified by Anthem Health of NY as necessary to provide the administrative services of this Agreement. Reports from this data will be furnished as needed for: (1) providing administrative services; (2) setting unit rates for the Monthly Fixed Cost.

Upon providing 10 days advance written notice to Sponsor, Anthem Health of NY has the right to examine or audit these records during the regular business hours of Sponsor.

SECTION 9 CLAIM RECORDS

Anthem Health of NY will maintain records of: (1) claims submitted under the Plan; and (2) claim payments made. The records will be maintained for the same period of time that similar records are maintained by Anthem Health of NY for its own insurance business.

Upon providing 10 days advance written notice to Anthem Health, the Sponsor has the right to examine or audit these records during the regular business hours of Anthem Health.

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SECTION 10 SPONSOR OWNERSHIP OF PLAN FILES AND REPORTS

All files and reports that are prepared and maintained by Anthem Health of NY under this Agreement are the sole property of Anthem Health, and copies will be made available within a reasonable time to the Sponsor upon written request. When this Agreement terminates copies of all of these files and reports will be delivered to the Sponsor on demand and in exchange for its receipt.

Sponsor's property shall not extend to any claim or payment data or other data recorded for or otherwise integrated into Anthem Health of NY's data processing systems during the ordinary course of business. Such data records shall be maintained by Anthem Health of NY for the same periods of time, in the same manner, and subject to the same confidentiality safeguards as similar data maintained by Anthem Health of NY in connection with its insurance business.

SECTION 11 RIGHT TO AUDIT

Each party shall be entitled to audit the books and accounts of the other relative to transactions subject to this Agreement. Such audits shall be scheduled at reasonable times and the other party shall cooperate to the fullest extent possible in accommodating all such audits.

SECTION 12 LIABILITY AND INDEMNITY

- a. It is mutually recognized that under this Administrative Service Agreement, Anthem Health of NY neither insures nor underwrites any liability of the Sponsor under the Plan. The Sponsor shall be deemed the "Plan Administrator" of the Plan, as that term is defined in the Employee Retirement Income Security Act (ERISA).

Anthem Health of NY in performing its obligations under this Agreement is acting only as agent of the Sponsor. The rights and responsibilities of the parties shall be determined in accordance with the law of agency except as otherwise provided in this Agreement. The Sponsor delegates to Anthem Health of NY authority to make determinations of benefit payments under the Plan and to pay such benefits. In connection with such determinations, Anthem Health of NY acknowledges that it is acting as fiduciary solely for benefit determination and review of denied claims for benefits under ERISA. In connection with its fiduciary powers and duties hereunder, Anthem Health of NY shall observe the standard of care and diligence required of a fiduciary under ERISA.

- b. The Sponsor shall retain the ultimate liability for claims filed under the Plan and all expenses incident to the Plan, except as specifically assumed in this Agreement by Anthem Health. Anthem Health of NY will undertake the defense of any suit brought with respect to a claim for Plan

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benefits and settle such suit when in its reasonable judgment it appears expedient to do so. The Sponsor agrees to pay the amount of Plan benefits included in any judgment or settlement with respect to a claim for Plan benefits up to the Stop Loss levels originally applicable when the claim was paid or denied. Anthem Health of NY will be liable for any other part of such judgment or settlement, including but not limited to legal expenses and punitive damages.

- c. The Sponsor agrees to indemnify and hold harmless Anthem Health, its directors, officers and employees:

- from any and all claims, suits and expenses, including penalties, attorneys' fees and court costs, that Anthem Health of NY may become liable for or shall pay upon or in consequence of any liability for premium, sales, excise, income (except federal), or any other taxes, including any penalties and interest paid with respect thereto, arising out of the performance by Anthem Health of NY of its service under this Agreement; and,
- from any and all liability for damages, losses, and expenses of whatever kind or nature, including penalties and attorneys' fees, which its directors, officers and/or employees shall or may incur by reason of any claims, demands, or lawsuits brought against Anthem Health, its directors, officers and/or employees by reason of any acts or omissions of the Sponsor's directors, officers and/or employees occurring during the operation of this Agreement, including but not limited to any claims, demands, or lawsuits brought against any party to this Agreement or their agents for breach of fiduciary duty under ERISA. This indemnity shall survive the termination of this Agreement.

- d. Anthem Health of NY agrees to indemnify and hold harmless the Sponsor, its directors, officers and employees:

-from any and all liability for damages, losses, and expenses of whatever kind or nature, including penalties and attorneys' fees, which its directors, officers and/or employees shall or may incur by reason of any claims, demands, or lawsuits brought against its directors, officers and/or employees by reason of any acts or omissions of Anthem Health's directors, officers and/or employees occurring during the operation of this Agreement, including but not limited to any claims, demands, or lawsuits brought against any party to this Agreement or their agents for breach of fiduciary duty under ERISA but solely for benefit determinations and review of denied claims. This indemnity shall survive the termination of this Agreement.

- e. Anthem Health of NY may seek the services of experts in performing its duties under this Agreement. Anthem Health of NY shall consult with the Sponsor or its designated legal counsel when legal or extraordinary benefit matters seem to be involved. The Sponsor hereby agrees to join the defense of any legal action involving actions of Anthem Health of NY taken at the request or demand of the Sponsor, subject to (b.) above.

- f. Anthem Health of NY will use care and reasonable diligence in exercising its powers and performing its duties under this Agreement. In the event of an erroneous payment of benefits through clerical error or for any other reason, Anthem Health of NY shall use reasonable efforts to recover any loss resulting therefrom, but will be held harmless by the Employer and not be required, at its own expense, to initiate legal process for such recovery.
- g. In the event of any litigation involving either Anthem Health of NY or the Sponsor concerning any matter under the Plan including a suit for benefits, each party to this Agreement shall retain sole authority to select legal counsel of its choice.

SECTION 13 PLAN RECOVERIES

The Plan will be credited with any amounts collected by Anthem Health of NY in the exercise of Plan provisions such as coordination of benefits or right of recovery. The amount credited under the right of recovery will be the Plan's proportionate share of the net recovery minus a fixed percentage fees of 25% of the gross recovery or, if outside counsel is used, 15% of the net recovery after a deduction for actual outside counsel fees and costs.

SECTION 14 ADVERTISING

The Sponsor agrees to only use Anthem Health's name in any release or printed forms approved by Anthem Health of NY in advance of its use.

SECTION 15 LAWS GOVERNING AGREEMENT

This Agreement shall be governed by, and shall be construed in accordance with ERISA and any other applicable Federal laws.

SECTION 16 SUBCONTRACTING

Administrative services of this Agreement may be performed in whole or in part by a party contracted to perform them by Anthem Health.

SECTION 17 AMENDMENT OF THE AGREEMENT

This Agreement is the entire contract between the Sponsor and Anthem Health. It may be amended from time to time. To be valid, amendments to the Agreement must be: (1) in writing; and (2) signed by an authorized representative of the Sponsor and an authorized officer of Anthem Health of

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NY(other than for a change in the Monthly Fixed Cost Factors). Changes in Monthly Fixed Cost Factors may be made by an authorized Anthem Health of NY employee in lieu of an officer of Anthem Health.

SECTION 18 WRITTEN NOTICE

Any notice which either party may be required or desire to give to the other party shall be in writing and delivered personally or by U.S. Mail addressed to the party at the address set forth below, unless written notice of a change in address is provided to the other party. Notice so mailed shall be deemed delivered seventy two (72) hours after deposit in the U.S. Mail.

SECTION 19 MODIFICATION OF PLAN

Modification or amendment of the Plan shall be duly communicated to Anthem Health of NY in detail and in writing by the Sponsor in advance of its proposed effective date.

The date for implementation of the modification or amendment will be mutually agreed upon and will be based on a reasonable appraisal of the effect thereof on functions and duties under this Agreement.

If revision in the Monthly Fixed Cost is deemed necessary by Anthem Health of NY by reason of the modification or amendment of the Plan, the revised Monthly Fixed Costs will be effective on the implementation date. The Monthly Fixed Cost on and after the implementation date shall be made on the basis of such revised Monthly Fixed Cost Factors.

Plan changes will be indicated by amendment to the Plan Document and Employee Booklet attached to and made a part of this Agreement. The term "Plan", on and after the effective date of the amendment, will mean the Plan as then amended.

SECTION 20 TERMINATION OF AGREEMENT

This Agreement shall terminate upon the earliest of the following:

1. The effective date of any state's or other jurisdiction's action which prohibits activities of the parties under this Agreement, or determines that the Sponsor is doing insurance business in contravention of that jurisdiction's law.
2. The date the Sponsor fails to fulfill all of its obligations under this Agreement. This includes, but is not limited to, the Sponsor's payment of claims for which it is liable within 10 days after the date Anthem Health of NY bills the Sponsor.

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3. Either party may terminate this Agreement without cause at any time, in which case, this Agreement will terminate at the end of the month after the other party has been provided with 31 days written notice of termination.
4. Any other date mutually agreeable to the Sponsor and Anthem Health.

Upon termination of this Agreement, Anthem Health of NY shall have the right to stop processing or paying claims immediately as of the effective date of such termination, regardless of when such claims were incurred. Complete information on all outstanding claims which are unpaid or received on or after that date shall be returned by Anthem Health of NY to the Sponsor. The Sponsor agrees to retrieve all Prescription Drug Cards, if applicable, and return them to Anthem Health.

SECTION 21 TERMINAL PROTECTION

At the Sponsor's request, Anthem Health of NY will continue to provide claim services and furnish related reports with respect to claims incurred while this Agreement was in effect and submitted for processing within the 12 month period following termination of this Agreement. Anthem Health of NY will only do so if:

- the Sponsor pays at termination the full Separation Charge and, if required by Anthem Health, submits either a letter of credit or pays the cash equivalent to 50% of the Terminal Aggregate Loss Level (as defined under the Stop Loss Policy) in one lump sum deposit. However, Anthem Health of NY reserves the right to require the letter of credit or cash deposit to be in any larger amount up to the Terminal Aggregate Loss Level, if in its judgment it deems it necessary. Anthem Health of NY will pay simple annual interest (as declared from time to time by Anthem Health of NY) from the date of receipt on any lump sum cash deposits.
- the Sponsor continues to fund the claims payable.

During the Terminal Protection period, all other Sections of this Agreement not in conflict with this provision will apply.

SECTION 22 BANKRUPTCY

If bankruptcy proceedings are commenced with respect to either party (the "Bankrupt") and if this Agreement has not otherwise terminated, then the other party (the "Other Party") may suspend all further performance of this Agreement until the Bankrupt assumes or rejects this Agreement pursuant to Section 365 of the Bankruptcy Code or any similar or successor provision. Any such suspension of

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further performance by the Other Party pending the Bankrupt's assumption or rejection will not be a breach of this Agreement and will not effect the Other Party's right to pursue any of its right under this Agreement.

SECTION 23 ARBITRATION

Any disputes, claims or counterclaims arising or relating to this Agreement shall be subject to and shall be finally and exclusively resolved by binding arbitration under the rules of conciliation and arbitration of the American Arbitration Association. Each party shall appoint an arbitrator, and the two arbitrators thus selected shall designate a third. If either party fails to appoint its arbitrator within thirty (30) days after receipt of notice of the appointment by the other party of its arbitrator, or if the arbitrators selected by the parties fail to appoint the third within thirty (30) days after both have been appointed, then the American Arbitration Association shall have the power, on the request of either party, to make the appointments which have not been made as contemplated above. The costs of arbitration shall be borne equally by the parties.

SECTION 24 MISCELLANEOUS

This Agreement supersedes any and all agreements regarding administrative services, including any and all amendments thereto, whether written or oral, previously entered into between Anthem Health of NY and the Policyholder.

The failure of either party to enforce or insist upon compliance with any provision of this Agreement in any instance shall not be construed as or constitute a waiver of the right to enforce or insist upon compliance with such provision either currently or in the future.

This Agreement may be executed simultaneously in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

The headings to the sections of this Agreement are designed merely to assist the reader and shall be disregarded in interpreting the terms hereof.

If any provision of this Agreement, or the application of any provision to any person or circumstance, shall be determined to be invalid or unenforceable, such determination shall not affect any other provision of this Agreement.

The parties will cooperate in all phases of the implementation of this Agreement including the supplying of all relevant information and documentation to each other and all other matters related to the implementation date agreed upon by the parties.

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This Agreement is signed by the following authorized officers of the Sponsor and Anthem Health.

THE SPONSOR

Family Golf Centers, Inc.
225 Broad Hollow Rd.
Melville, NY 11747

Anthem Health & LIFE**INSURANCE COMPANY of New York**

One Centennial Avenue
Piscataway, NJ 08855-1326

By: Krishna P. Shetty
Title: Chief Operating Officer
Date: 12/22/97

By: _____
Title: _____
Date: _____

(Submitting State Use)

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AMENDMENT

To Be Attached To and Made a Part of Policy No. N

Issued By

Anthem Health & Life Insurance Company of New York

To

Family Golf Centers, Inc.

Effective Date: 01/01/98

TERMINAL STOP LOSS-PROTECTION AMENDMENT

We and the Sponsor agree that the Policy is modified, as follows:

At the Sponsor's request we will provide Terminal Stop Loss Protection for run out claims during the 12 month period following termination of the Policy. The Terminal Stop Loss Protection is subject to the terms of this Amendment.

"Run out claims" are LOSSES payable under the PLAN which are:

- (i) incurred while this Policy is in effect; and
- (ii) unpaid as of the date this Policy terminates; and
- (iii) paid during the Terminal Stop Loss Protection period.

1. This Terminal Stop Loss Protection Amendment will be a part of the Policy Protection when you apply for the Policy. This Amendment may not be canceled.
2. After the Policy ends and during the Terminal Stop Loss Protection period, you are liable for all LOSSES paid by the PLAN up to the TERMINAL AGGREGATE STOP LOSS LEVEL.

We are liable for LOSSES paid by the PLAN in excess of the TERMINAL AGGREGATE STOP LOSS LEVEL.

You are liable for all LOSSES paid by the PLAN after the Terminal Stop Loss Protection period.

3. The TERMINAL AGGREGATE STOP LOSS LEVEL is:

(a) If the Policy ends on an anniversary date of the Policy, the sum of (i) and (ii):

- (i) the Separation Liability; and

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(ii) the CUMULATIVE AGGREGATE STOP LOSS LEVEL for the last Policy Month before this Policy ends, reduced by the sum of all LOSSES paid for that Policy Year before the Policy ends and which is your liability.

However, you must repay us the amount of cumulative paid LOSSES that exceed the CUMULATIVE AGGREGATE STOP LOSS LEVEL for that last Policy Year, if any. In no event will such repayment exceed the Terminal Aggregate Stop Loss Level. Any such repayment reduces the amount owed by you under the Terminal Aggregate Stop Loss Level. Such repayment will be due within 10 days of the date we bill you.

(b) If the Policy does not end on an anniversary date of the Policy, the sum of (i), (ii), and (iii):

(i) the Separation Liability; and

(ii) the CUMULATIVE AGGREGATE STOP LOSS LEVEL for the last Policy Month before this Policy ends, reduced by the sum of all LOSSES paid for that Policy Year before the Policy ends and which is your liability; and

(iii) The CUMULATIVE AGGREGATE STOP LOSS LEVEL for the last Policy Month of the Policy Year prior to the Policy Year in which this Policy ends, reduced by the sum of all LOSSES paid for that Policy Year and which were your liability.

However, you must repay us the amount of cumulative paid LOSSES that exceed the CUMULATIVE AGGREGATE STOP LOSS LEVEL, if any, in the last Policy Year and the Policy Year prior to the Policy Year in which this Policy ends. In no event will such repayment exceed the Terminal Aggregate Stop Loss Level. Any such repayment reduces the amount owed by you under the Terminal Aggregate Stop Loss Level. Such repayment will be due within 10 days of the date we bill you.

SEPARATION LIABILITY is obtained by multiplying the Separation Liability Factor by the average number of units in each Class of Covered Units under the Plan for the last three Policy Months before the Policy ends. We will give you the Separation Liability Factor(s) for the coverages subject to this amendment.

4. When this Policy ends, you will pay us an amount equal to the Separation Charge. The Separation Charge is due within 10 days of the date we bill you. The Separation Charge is equal to the product of (a) and (b):

(a) the Separation Charge Factor; and

(b) the average number of units in each Class of Covered Units covered under the Plan for the last three Policy Months before the Policy ends.

We will give you, in writing, the Separation Charge Factor(s) for the coverages subject to this amendment.

If required by us, you will give us either a letter of credit or the cash equivalent to 50% of the Terminal Aggregate Stop Loss Level (as determined by us) in one lump sum deposit. However, we reserve the right to require the letter of credit or cash deposit to be in any larger amount up to the Terminal Aggregate Loss Level, if in our judgment we deem it necessary.

5. The Terminal Stop Loss Protection will end on the earliest of the following:

(a) 12 months after termination of the Policy; or

(b) the last day of the period for which the Sponsor has provided funds for payment of run out claims.

You are liable for all LOSSES paid by the PLAN after this Terminal Stop Loss Protection ends.

The Provisions of the Policy - to the extent that they apply - will survive the termination of the Policy.

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All other provisions and conditions of the Policy remain in effect.

IN WITNESS WHEREOF the Sponsor and Anthem Health & Life Insurance Company of New York have signed this Amendment as of its Effective Date.

Krishna P. Chong Chief Operating Officer
Signature of Sponsor and Title

Anthem Health & Life Insurance Company of New York

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Anthem Health & Life Insurance Company of New York
Home Office: Atrium Two Building, 221 East Fourth Street, Suite 2600, Cincinnati, OH 45202-4151
Administrative Office: 1 Centennial Avenue, Piscataway, NJ 08853-1325
(908) 980-4300

SPONSOR: Family Golf Centers, Inc.

POLICY NUMBER:

EFFECTIVE DATE: 01/01/98

POLICY ANNIVERSARIES: 01/01/99 and each January 1st after that.

In this Policy the words "We", "Us" and "Our" refer to Anthem Health & Life Insurance Company of New York, and the words "you" and "your" refer to the Sponsor.

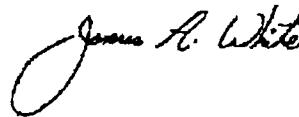
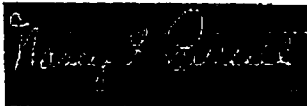
We agree to pay you for losses you incur, subject to the terms of this Policy.

The provisions on the pages which follow are a part of this Policy.

This Policy is delivered in the State of , and is governed by its laws.

This Policy is
issued in return
for the payment of
required premiums.
It will take
effect at 12:01
A.M., standard time
at the Sponsor's

address on the Effective Date shown above.




Registrar

Jul 25 00 11:56a

Kim A. Graf

631-261-4977

p. 19

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GROUP STOP-LOSS INSURANCE POLICY
Non-Participating

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GSL-TC

DEFINITIONS

These terms have the meaning shown:

TERMMEANINGLOSS

Any amount paid as benefits under the Plan or to satisfy a judgement, award or settlement with respect to a claim for benefits under the Plan. However, Loss does not include (a) any claim expenses, salaries or other compensation paid by you; (b) any taxes, interest, penalties or damages, punitive or otherwise, levied, assessed or imposed against you because of any litigation, arbitration or hearing with respect to your duties and liabilities under the Plan, (c) any benefits which exceed the amount you must pay a claimant, under the provisions of the Plan, (d) claims paid with respect to an employee and/or his or her dependents on whom coverage is rescinded due to misrepresentation of information on their enrollment forms and/or health statements, or (e) claims paid with respect to an employee and/or his or her dependents who are either not eligible for coverage under the Plan or for whom Plan coverage has not yet taken effect. Loss shall not include any amount you pay to satisfy a judgement, award or settlement, with respect to a claim for benefits under the Plan, which is more than the amount we determine to be a reasonable settlement.

Also, Loss shall not include any money recovered under a right of recovery, co-ordination of benefits, or provisions of similar intent. Any money recovered will be redistributed as follows:

1. first, to us to be applied to reduce the amount we have paid under the Specific Stop Loss provision;
2. second, to us to be applied to reduce the amount we have paid under the Aggregate Stop Loss provision; and
3. third, to you;

All money recovered will be applied to the accounting for the Policy Year during which the claim is paid. If the claim expenses are paid in more than one Policy Year, we will apportion the money on a pro rata basis according to the amount of claim expenses paid in each Policy Year.

MEDICAL CARE

The coverage for hospital, surgical or medical expenses under the Plan. It does not include the prescription drug coverage (drug card program), if a part of the Plan approved by us.

PLAN

The self-funded accident and sickness plan which you have established for employees and their dependents, as that plan is in effect on the Effective Date of this Policy, or as that plan is subsequently amended. The plan, and any subsequent amendments must be approved by us. It includes hospital, surgical or medical, prescription drug, (Drug Card Program) dental, and weekly income coverages when a part of the Plan approved by us. It does not include life insurance, accidental death or dismemberment insurance, and long term disability insurance coverages.

POLICY

ANNIVERSARY The first Policy Anniversary will be the date 12 months after the Effective Date. Policy Anniversaries will occur annually from that date.

POLICY MONTH

Calendar Month.

POLICY YEAR

The 12 policy months in a row which follow the Effective Date, or, if later, a Policy Anniversary. The last Policy Year ends when this Policy terminates.

**SUBSTANTIVE
CHANGE**

A Major change in the Plan, such as: (a) a change in the benefits provided by the Plan; (b) the addition or deletion of employee units, locations, affiliates, or subsidiaries; (c) a reduction in lives below 25 covered employees in any policy month; (d) a change in the number of covered employees or dependents of more than 25 percent from one policy month to the next; (e) a change in the number of covered employees or dependents of more than 10% per month, over any three policy months in a row.

SPONSOR

You, and any subsidiaries and affiliates named in the Application, or subsequently approved by us.

SCHEDULESpecific Stop-Loss Level

We will give you, in writing, the initial Specific Stop-Loss Level for Losses for Medical Care.

Aggregate Stop-Loss BenefitsClass of Covered Units

Employees Only

Dependent Unit

Monthly Aggregate Factors

We will give you, in writing the initial Monthly Aggregate

Factors.

The Monthly Aggregate Stop Loss Level for each policy month is the sum of the products obtained by multiplying the number of units in each Class of Covered Units under the Plan at the beginning of the third immediately preceding Policy Month by the applicable Monthly Aggregate Factor. However, for the first 3 months that this Policy is in effect, such number shall be the number of the units covered under the Plan on the Effective Date. The Cumulative Aggregate Stop Loss Level in any Policy Month is the sum of the Monthly Aggregate Stop Loss Levels in that month and all previous Policy Months in the current Policy Year.

TABLE OF PREMIUM CHARGESCoveragePremium Charge

Stop-Loss Benefits

We will give you, in writing, the amount of the initial premium charge.

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STOP LOSS INSURANCE PROVISIONS**STOP-LOSS BENEFITS**

This Policy applies only to a Loss paid under the Plan, which is paid while this Policy is in force.

A Loss is considered to have been incurred as of the date the service, treatment, drug or supply is furnished to a covered employee or dependent. A Loss for weekly income benefits is considered to have been incurred on the date on which payment is due.

A Loss is considered to have been paid on the date a check or draft is issued to a claimant, pursuant to the terms of the Plan.

SPECIFIC STOP-LOSS BENEFITS

You are liable for Losses paid for Medical Care, for any individual, during a Policy Year, up to the Specific Stop-Loss Level.

We are liable for Losses paid for Medical Care for any individual during a Policy Year, in excess of the Specific Stop-Loss Level.

If there is a Substantive Change in the Plan, we may change the Specific Stop-Loss Level by giving you advance written notice before that change.

AGGREGATE STOP-LOSS BENEFITS

For the purpose of determining the Monthly Aggregate Stop Loss Level, Cumulative Aggregate Stop Loss Level, or Aggregate Stop-Loss Benefits, Loss shall not include any Loss reimbursed under the Specific Stop Loss Benefits provided by this policy.

In any Policy Year, you are liable for Losses paid up to the Cumulative Aggregate Stop Loss Level. You will be liable for repayment of Excess Payments in any Policy Month in which the cumulative paid Losses are less than the Cumulative Aggregate Stop Loss Level for that Policy Year. (Excess Payments are funds we have provided for paid Losses under this Policy because the paid Losses are in excess of the Cumulative Aggregate Stop Loss Level during a Policy Year.) The repayment will not exceed the amount by which the Cumulative Aggregate Stop Loss Level is greater than the cumulative paid Losses.

We are liable for cumulative paid Losses in excess of the Cumulative Aggregate Stop Loss Level.

If there is a Substantive Change in the Plan, we may change the Monthly Aggregate Factors by giving you advance written notice before that change.

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MEDICAL POLICY CONVERSION PRIVILEGE

An employee who has been covered under the terms of the Plan and whose coverage under that Plan ceases, other than for discontinuance of plan contributions by the employee, may request us to issue a conversion policy if, on the date coverage ceased, this Policy was still in force.

The conversion policy is an individual medical care policy which will cover the employee and all eligible dependents who were covered by the Plan.

We will issue the conversion policy subject to the following conditions:

- (1) We will not require proof of good health.
- (2) Written application for conversion and the first premium for the conversion policy, must be delivered or mailed to us, at our Home Office, within 31 days after the date on which coverage under the Plan ceases.
- (3) The conversion policy and the coverage it provides will be that then customarily issued by us in the state where the employee resides. The premium for the policy will be based on our normal rate for the class of risk and ages of the person to be covered, and the type and amount of insurance applied for. We use the rate in effect on the later of:
(a) the date of the application, or (b) the date the new policy takes effect.
- (4) We will not allow a person to convert who is eligible for Medicare. We will also not allow a person to convert who is insured under other coverage. This includes insurance plans, subscriber plans and prepayment types of plans and programs, if the converted policy would duplicate benefits or make the person overinsured.
- (5) The conversion policy will take effect on the day after the date on which coverage under the Plan ceases.

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- (6) We may request information before a premium due date to see if a covered person has other similar coverage. If we do not get this information, we may refuse to pay for an expense in question. We can reduce benefits under the new policy by the amount of any benefits payable for the same expenses under the group coverage. And during the first year of the new policy, we can reduce benefits so that they do not exceed the benefits that would have been paid under the group coverage. Any condition excluded under the group coverage may be excluded in the new policy.
- (7) A conversion policy must be approved by the insurance department of the state where the policy is to be issued.

A conversion policy may only be issued to a person who is resident of the United States, and who has been covered under the Plan for at least 3 months in a row.

A dependant may convert to his or her own policy as follows:

- at an employee's death. The spouse, if any, may apply for a policy to cover all eligible members of the family unit who are then covered under the medical care coverage of the Plan. Otherwise, each surviving child may apply for a Policy.
- after divorce or annulment, the employee's spouse may apply for his or her own policy.
- when a child marries or reaches the age limit under the PLAN, he or she may apply for his or her own policy.
- when the Plan ends for the spouse and the employee remains covered under the Plan, the spouse may apply for his or her own policy.

The terms of the policy to be issued and the conditions an employee must meet in order to convert also apply to these dependants.

GENERAL PROVISIONS**THE PLAN**

We are not responsible for the accuracy or completeness of any descriptive material you publish, issue, or disseminate, in connection with the Plan.

You are responsible to investigate, settle, or defend any claim made, or suit brought, or proceeding instituted against the Plan. We may participate, at our sole option and at our own expense, in any litigation, arbitration, or hearing, which will affect our liability under this Policy or the validity of the Plan, and in which we are not named as a party.

Any objection, notice of legal action, or complaint you receive on a claim processed and on which it reasonably appears benefits will be payable under this Policy, shall be brought to the immediate attention of our Claim Department.

You will submit any proposed Substantive Change in the Plan to us, in writing, at least 31 days before its effective date, for determination of its effect upon our liability and any resulting change in the terms of this Policy.

If you do not give us such notice, our liability is limited to the lesser of the benefits payable: (a) under the Plan as revised; or (b) as if the Plan had not been amended.

If any state or government entity assesses a premium tax or fee with respect to losses paid (as distinct from the premiums you pay to us under the Plan), you shall reimburse us upon demand to the extent of such tax or fee. You shall also reimburse us for any expenses we incur in connection with such assessment, such as penalties, fines and/or interest.

LIABILITY AND INDEMNIFICATION

Except as specifically provided in any Rider, attached to and forming a part of this Policy, we have no obligation to any third party.

Our liability under this Policy is limited to reimbursing you for payments you make on behalf of covered persons, for expenses covered under the Plan. We are not liable for punitive or exemplary consequential damages. You hold us harmless from damages, of any kind, which are not caused by our own acts or omissions.

We are not responsible for any liability you assumed under any contract or agreement other than the Plan.

ENTIRE CONTRACT: CHANGES

This Policy is contract solely between you and us. This Policy and your attached application are the entire contract.

Statements you make in any application are representations and not warranties. Since a copy of the application for this Policy is attached, any statement in it may avoid the insurance, reduce benefits, or be used to defend a claim under this Policy.

No change in this Policy will be valid unless approved and signed by an authorized officer of Anthem Health & Life Insurance Company of New York. Any change will be made part of this Policy by Rider. If not provided for by the terms of this Policy, the change must also be agreed to in writing by you.

Only an authorized officer of Anthem Health & Life Insurance Company of New York can (a) accept any representations or information not contained in the application; (b) modify, enlarge or vary this Policy; or (c) waive any of this Policy's requirements. No assignment of your interest under this Policy shall be binding upon us.

DATA AND REPORTS

You shall maintain such records as are reasonably required by us, and will furnish to us such data as we may reasonably require for administration of this Policy.

We will give you an annual statement of: (i) the premium we received, and (ii) the amount of losses we reimbursed, or will reimburse, for each Policy Year. This report will be sent to you or, at your written request within 60 days after we receive the final data we require for that Policy Year.

RIGHT TO AUDIT

At any reasonable time, we may inspect any of your records which relate to this Policy.

COMPLIANCE WITH LAW

If, on its Effective Date, any provisions of this Policy conflict with any applicable statutes, those provisions are amended to conform to the statute's minimum requirements.

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RIGHTS ON RECOVERY

Damages, expenses or benefits you recover from a third party will not be considered LOSSES under the Plan. If we have reimbursed you for all or part of any payment, and that payment is later recovered from a third party, you must repay us to the extent of the recovery, even if the Policy is no longer in force on the date of recovery. Repayment may be reduced by the reasonable and necessary expenses you incur in recovering from the third party.

WORKER'S COMPENSATION UNAFFECTED

The Policy is not in lieu of, and does not affect any requirements for, Worker's Compensation insurance coverage.

OTHER COVERAGE

The stop-loss insurance provided by this Policy shall be excess over any other valid and collectible insurance, excess insurance, reinsurance, or indemnity coverage payable to you, unless such other insurance, excess insurance, reinsurance, or indemnity coverage is specifically issued to be in excess of the insurance provided by this Policy.

PREMIUM PAYMENTS

While this Policy is in force, premiums are due on the Effective Date and on the first day of each later Policy Month.

You must pay all premiums to us at our Home Office.

GRACE PERIOD

We will allow a 31 day grace period for payment of each premium due after the first. During this period the Policy will remain in force, unless it ends during this period as set forth in the "POLICY TERMINATION" section of these GENERAL PROVISIONS.

AMOUNT OF PREMIUM

Subject to our right to change premiums and premium components, the amount of each premium for this Policy will be sum of: (a) the premium charges; and (b) such amounts as may be required by any Rider attached to this Policy.

We may, from time to time, change the amounts and rates of the premiums and premium components. Any such change will become effective: (a) not less than 31 days after we mail you written notice of it; and (b) in the absence of a Substantive Change, not before each Policy anniversary.

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If there is a Substantive Change in the Plan, we may change the premium rates.

POLICY TERMINATION

This Policy will automatically terminate at the earliest of:

- (a) The date the Plan terminates, as specified to us by you;
- (b) The date a Substantive Change in the Plan occurs without our prior written consent;
- (c) The end of the Grace Period following the due date of the first premium in default.

This Policy may also be terminated:

- (a) As of the last day of a Policy Year, by either party giving 31 days prior written notice to that effect to the other party; or
- (b) As of the last day of the policy year the Sponsor becomes a small employer as defined in New York Insurance Law Section 3231; or
- (c) As of any date agreed to between you and us.

When this Policy terminates, we will not be liable for any LOSS sustained after the date of termination.

If there is a Substantive Change in the Plan, we may, as a condition to agreeing to such Substantive Change, change any or all of the following:

- (a) the Monthly Aggregate Factors, if any;
- (b) the Specific Stop Loss Limit, if any; or
- (c) the Stop Loss Premium Rates.

If this Policy terminates for any reason, you still owe us all premiums due and unpaid for the period for which this Policy was in force.

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ARBITRATION

All disputes between you and us, upon which an amicable understanding cannot be reached, will be decided by arbitration.

The Court of Arbitrators, which will be held in the city where the Sponsor is located, shall consist of three arbitrators familiar with employee benefit plans.

Each party to this Policy will select an arbitrator, the third to then be chosen by the first two.

If the two arbitrators are unable to agree on the selection of the third arbitrator, the choice shall be left to the American Arbitration Association.

The arbitrators shall be free to reach their decisions by applying the principles of equity, and customary practices of the insurance and reinsurance industry, rather than the strict application of rules of law. They shall decide by a majority of votes, and there shall be no right of appeal. The cost of arbitration shall be borne by the loser, unless determined otherwise by the arbitrators.

LEGAL ACTIONS

No legal action for benefits may be brought against us:

- (a) less than 60 days after proof of loss is sent to us, as required; or
- (b) more than 3 years after the time for submitting proof has ended.

ARBITRATION

All disputes between you and us, upon which an amicable understanding cannot be reached, will be decided by arbitration.

The Court of Arbitrators, which will be held in the city where the Sponsor is located, shall consist of three arbitrators familiar with employee benefit plans.

Each party to this Policy will select an arbitrator, the third to then be chosen by the first two.

If the two arbitrators are unable to agree on the selection of the third arbitrator, the choice shall be left to the American Arbitration Association.

The arbitrators shall be free to reach their decisions by applying the principles of equity, and customary practices of the insurance and reinsurance industry, rather than the strict application of rules of law. They shall decide by a majority of votes, and there shall be no right of appeal. The cost of arbitration shall be borne by the loser, unless determined otherwise by the arbitrators.

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No legal action for benefits may be brought against us:

- (a) less than 60 days after proof of loss is sent to us, as required; or
- (b) more than 3 years after the time for submitting proof has ended.

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**INSTRUCTIONS FOR COMPLETING
ATTACHMENTS 2 through 2.6**

For payors making an election pursuant to sections 2807-j and 2807-t of the Public Health Law, please complete the applicable Attachments #2 through #2.6. TYPE all forms and submit to Anthem Health who will file them with the Pool Administrator for the State of New York.

Election forms must be received in accordance with the schedule below for an election to be valid.

FOR ELECTION TO BE EFFEC- TIVE ON:	ELECTION MUST BE POSTMARKED BY:
April 1, 1997	March 3, 1997
July 1, 1997	June 2, 1997
October 1, 1997	September 2, 1997
January 1, 1998	December 2, 1997
January 1, 1999	December 2, 1998

NOTE: A payor that becomes newly licensed pursuant to the Insurance Law or certified pursuant to Article 44 of the Public Health Law or a self-funded plan that had not previously provided third-party coverage, may elect direct payments to begin April 1, July 1, or October, 1 of any year provided the completed election form is received by the Department postmarked no later than 30 days prior to these dates.

Attachment #2 is the form by which a payor voluntarily elects to make public goods payments directly to the Department's pool administrator. Signature of the chief financial officer or other duly authorized individual binds the payor to make direct pool payments for all its public goods funding obligations, file monthly reports and remit funds in accordance with the Health Care Reform Act (HCRA) provisions and Department requirements, and represents an agreement as to the jurisdiction of the State for purposes of enforcing payments required under Public Health Law sections 2807-j and 2807-t. This does not, in any way, preclude a payor from litigating other issues in Federal court such as ERISA based challenges, etc.

TPA's making public goods payment directly on behalf of represented funds that have elected must complete and submit Attachment #2-T in addition to their submission of each represented self-insured fund's separately completed election form (Attachment #2) (see instructions which follow). If the TPA is also an insurer, or self-insured for their own lines of business, they must complete their own separate election forms.

The form is to typed, signed in BLUE INK (original signature only;

photocopies and faxes will not be acceptable)

(1) Type in the effective date; refer to the table above.

(2) The federal employer identification number is that used by the payor for federal tax purposes.

(3) The payor name is that of the incorporated entity, local government, self-insured fund. A payor should also include any assumed name(s) (d/b/a) under which it is doing business.

(4) The address is that of the listed payor.

(5) The contact person is the person that will be responsible for providing the Department or providers related information regarding the payor's election, lines of business, and claims processing.

(6) The phone number should be that of the contact person.

If the election submission is for a payor that is utilizing a TPA/ASO for claims processing, the following information must also be provided.

(1) The name of the TPA/ASO representing said payor.

(2) The federal employer identification number used by the TPA/ASO for federal tax purposes.

Attachment 2.1 must be completed by all payors making an election and represents a payor's attestation of the coverage it provides. A payor electing to pay the Department's pool administrator directly is making an election for all its product lines. For an election application to be considered by the Department, this attachment must be completed by the payor and submitted with Attachment #2 postmarked in accordance with the table on page 1 of these instructions. The form is to be completed as follows:

(1) In each payor category which applies, the payor should mark an X in each column to indicate whether the payor provides such coverage. Each box marked with an X necessarily represents the lines of business included in the payor's election. As stated before, a payor is required to elect for all its product lines. Shaded areas should not be checked.

(2) If an Article 43 Insurance Law corporation or licensed insurer has a separate incorporation for its Article 44 Public Health Law business, that corporation must check the appropriate boxes on a single election form. Otherwise, the Article 44 Public Health Law business is considered to be a product line of the Article 43 or commercial payor and the payor is required to make a single election for this and all other types of coverage provided by the corporation. A payor who does not fall into any of the categories listed should check Other in the payor identification section and explain their payor type. The Other payor category is also to be utilized by insurers not licensed or operating under New York State statutes. The Other payor category would not be utilized by self-insured funds regardless of where they are domiciled. It is anticipated that the only instance where an entity making an election would fall within

more than one category are as follows:

- a self-insured fund for both workers' compensation and employee health benefits may utilize a TPA for one type of coverage but not the other. In this instance the fund would provide (a) an election form to the TPA for the type of coverage for which it is utilizing the TPA and (b) a separate election form to the Department's pool administrator for the self-insured business that is not utilizing a TPA. The self-insured fund would, however, be required to make payments directly to the Department's pool administrator for both lines of coverage.
- a local government may have several roles: as a payor of services provided to correctional facility patients; and also be self-insured for employee health benefits or workers' compensation. Where no TPA is involved, the local government should provide a single election form identifying itself as being within more than one payor category. Where a TPA is utilized for the self-insured option, the local government would provide to the TPA a separate election form for its self-insured payor category. If a local government chooses, it may elect to make direct payments for correctional facilities patients.

Attachment #2.2 must be submitted in accordance with the previous schedule and must be filled out by all electing payors that have marked any box on Attachment 2.1 indicating they provide coverage of a type that requires covered lives payments. Actual payments to the pool are not to be calculated from this data but from actual enrolled covered lives during the HCRA period. This information is required by the HCRA to be submitted as part of the election application.

I. Covered Lives: For the month of June of the year prior to the assessment year, i.e., June of 1996 for any 1997 effective dates, enter the number of individuals covered lives and family unit covered lives residing in New York which were included in your membership roles, by region. Enter the number of individual covered lives in row (A) and the number of family units in row (B).

II. Apportionment of Covered Lives: For payors that have reached agreement to apportion the cost of their covered lives assessments with another inpatient payor providing unduplicated coverage for a single contract holder, data must be entered in this section of the form. The payor must identify the number of covered lives, from within the total number of covered lives reported in section I, which are the subject of apportionment. The total number of individual covered lives subject to apportionment on lines C and F should correspond to the total of such amounts reported on Attachment #2.2 and should reflect an agreement by the payors as to the number of individual covered lives and family units each had on their membership rolls for the month of June 1996. The number of individual covered lives

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subject to apportionment should be entered in row (C) and The number of family unit covered lives subject to apportionment should be entered in row (F). The apportionment percentage is the percentage of assessment cost which you will be paying in the HCRA period. The apportionment percentages for the individual and family unit covered lives should be entered (to the nearest tenth) into rows (D) and (G), respectively. Where a payor has multiple apportionment agreements, the apportionment percentage in row (D) and (G) should reflect a composite percentage weighted to reflect the relative number of covered lives in each agreement (see attached Weighted Average Apportionment Calculation). The apportioned number of covered lives is the product of the number of lives subject to apportionment multiplied by the apportionment percentage. The apportioned number of individual covered lives should be entered in row (E) and the apportioned number of family unit covered lives should be entered in row (H).

III. Net Covered Lives: Net Covered Lives are derived by the following calculation: total number of covered lives subject to apportionment plus apportioned covered lives. See the formula next to each of the rows for individual and family unit covered lives.

Attachment #2.3 must be completed by payors that have an apportionment arrangement for covered lives payments. The numbers presented on this attachment provide the Department with the data necessary to project anticipated pool receipts from this particular funding mechanism. Actual payments to the pool will be calculated not from this data but from actual enrolled covered lives during the HCRA period. These payors are required to list all other payors with which they have reached an agreement to apportion their covered lives assessments for unduplicated inpatient coverage by listing each such payor by name and federal employer identification number (EIN). Note: All entities listed on this attachment must be electing payors and the resultant apportionment between such electing payors must add up to 100% of the covered lives being apportioned. The number of individual and family unit covered lives subject to apportionment pursuant to an agreement should be entered in the appropriate columns on the attachment and should reflect an agreement by the payors as to the number of individual and family unit covered lives each had on their membership roles for the month of June of the year prior of the assessment year. The total number of individual and family unit covered lives subject to apportionment on this form should correspond to the total of the amount on lines C and F on Attachment #2.2. If additional space is necessary, please photocopy the form and renumber the first column (No.). In order for the Department to accept the apportionment of covered lives, a copy of each apportionment agreement must be attached and must be signed in BLUE INK. The apportionment agreement must be signed by the Chief Financial Officer or other duly authorized individual of the payors involved in the apportionment and the percentage of cost being assumed by each payor.

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Attachment #2.5 must be typed, signed in BLUE INK, and completed by a payor whose status has changed from the original election submission filed.

Attachment #2.6 must be typed, signed in BLUE INK, and completed by a payor whose status has changed from the original election as it relates to whether a TPA is utilized for claims processing. This form will act as an addendum to Attachment #2.4 of an original election submission for both the previous and present TPA. The form must be signed by the payor.

Plan #:

ATTACHMENT 2
PUBLIC GOODS SURCHARGE/COVERED LIVES
ELECTION FORM
for PAYORS

OTHER THAN
THIRD PARTY ADMINISTRATORS or ADMINISTRATIVE SERVICES ORGANIZATIONS

TYPE and use BLUE INK when signing

Effective Date:

FEDERAL TAX
IDENTIFICATION # (EIN):

PAYOR NAME:

D/B/A (IF APPLICABLE):

ADDRESS:

CONTACT PERSON:

PHONE #:

If the above referenced entity is a payor that utilizes a third party administrator or administrative services organization for claims processing, please provide the following information:

TPA/ASO NAME:

TPA/ASO FEDERAL EMPLOYER IDENTIFICATION # (EIN):

By signature below, the above entity elects to make Public Goods surcharge payments directly to the Department's pool administrator for all its lines of business and agrees to:

1. remit to the Department's pool administrator required surcharge payments for all applicable services on a monthly basis on or before the 30th day following the calendar month for which monies have been paid to designated providers of service;
2. provide the Department's pool administrator monthly certified reports on or before the 30th day following the calendar month for which monies have been paid which separately report patient service expenditures for services provided by designated provider type(s) (i.e., hospital inpatient, hospital outpatient, diagnostic & treatment center, laboratory, or ambulatory surgery center) by product line.
3. Provide the Department with certification of data and access to allowance expenditure data upon request for audit verification purposes; and

4. the jurisdiction of the state to maintain an action in the courts of the State of New York to enforce any provision of Section 2807-j of the Public Health Law.

By signature below, the above entity also agrees to make Public Goods covered lives payments directly to the Department's pool administrator in instances where it provides inpatient coverage as a corporation organized and operating in accordance with Article 43 of the Insurance Law, an organization operating in accordance with Article 44 of the Public Health Law, a self-insured fund or third party administrator acting on behalf of such fund or a commercial insurer licensed to do business in New York State and authorized to write accident and health insurance and whose policy provides inpatient coverage on an expense incurred basis. In such instances the above entity agrees to:

1. remit to the Department's pool administrator within 30 days after the end of each month one-twelfth of both the individual and family unit annual assessment amounts for each of the individuals and family units residing in the state which were included on the payor's membership rolls for all or a portion of the prior month and for which the payor covered general hospital inpatient care, including retroactive additions and deletions;
2. provide the Department with data certification and access to individual and family unit data, upon request, for audit verification purposes; and
3. the jurisdiction of the state to maintain an action in the courts of the State of New York to enforce any provision of section 2807-t of the Public Health Law.

By signature below, the Chief Financial Officer or other duly authorized individual of the above entity certifies that the data submitted on all applicable attachments has been carefully prepared in accordance with instructions provided, and to the best of his/her knowledge, the information presented is accurate and correct.

Signature: Kristal Khan Title: C.O.O.
Chief Financial Officer or Duly Authorized Individual

Date: 12/23/97

Note: Payors making an election are only agreeing to the jurisdiction of NYS courts for purposes of enforcing payments required under 2807-j and 2807-t. This doesn't, in any way, preclude a payor from litigating other issues in Federal court such as ERISA based challenges, etc.

**ATTACHMENT 2.1
PUBLIC GOODS SURCHARGE/COVERED LIVES
ELECTION FORM-COVERAGE INFORMATION
(SEE ATTACHED FOR FURTHER EXPLANATION OF SURCHARGE OBLIGATIONS)**

PAYOR NAME:
TPA NAME:

FEDERAL ID #:
TPA FEDERAL ID#:

MARK AN "X" IN EACH COLUMN TO INDICATE TYPE OF COVERAGE BY PAYOR TYPE

TYPE OF PAYOR:	IDENTIFICATION OF TYPE OF COVERAGE									
	NUBILITY COVERAGE	FINO NON-RECAP COVERAGE	RELIANT COVERAGE	NEW YORK FINO RECAP COVERAGE	NEW YORK GOVT PROGRAM COVERAGE NYS LOCAL GOVT COVERAGE	NEW YORK GOVT PROGRAM COVERAGE NYS LOCAL GOVT COVERAGE	NEW YORK GOVT PROGRAM COVERAGE NYS LOCAL GOVT COVERAGE	NEW YORK GOVT PROGRAM COVERAGE NYS LOCAL GOVT COVERAGE	NEW YORK GOVT PROGRAM COVERAGE NYS LOCAL GOVT COVERAGE	OTHER COVERAGE
Corporate-Owned & Operating in accordance with Article 40 of the Insurance Law										
Corporate-Owned & Operating in accordance with Article 40 of the Insurance Law, not incorporated in Commercial Insurance under Article 40 of the Insurance Law										
Corporate-Owned & Operating in accordance with Article 40 of the Insurance Law, not incorporated in Commercial Insurance under Article 40 of the Insurance Law										
Self-Insured Fund with the Fund Party Administrator/Underwriter Party Only Organization for Claims Recovery										
Self-Insured Fund with a Third Party Administrator/Underwriter Party Only Organization for Claims Recovery										
New York State Commercial Agency New York State Local Government										
Other (Please explain below) (Includes State/Local government other than New York and Commercial Insurance and RECA not licensed in NY)										

EXPLANATION OF "OTHER" PAYOR IDENTIFICATION

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 11/11/2011 BY 60322
EXPLANATION OF SURCHARGE OBLIGATIONS
FOR ELECTING PAYORS

- Corporation organized and operating in accordance with Article 43 of the New York State Insurance Law offering:
 - Indemnity Coverage with an expense incurred inpatient hospital component, thus requiring an 8.18% surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident insureds.
 - Indemnity Coverage without an expense incurred inpatient hospital component, thus requiring an 8.18% surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds.
 - HMO non-Medicaid managed care coverage, thus requiring an 8.18% surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident non-Medicaid insureds.
 - HMO Medicaid managed care coverage, thus requiring an 5.98% surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident Medicaid managed care enrollees.
- Corporation organized and operating in accordance with Article 44 of the New York State Public Health Law not incorporated as a NYS licensed commercial insurer or under Article 43 of the New York State Insurance Law offering:
 - HMO non-Medicaid managed care coverage, thus requiring an 8.18% surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident non-Medicaid managed care enrollees.
 - HMO Medicaid managed care coverage, thus requiring an 5.98% surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident Medicaid managed care enrollees.
- Commercial Insurance Corporation licensed by New York State offering:
 - Indemnity Coverage with an expense incurred inpatient hospital component, thus requiring an 8.18% surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident insureds.
 - Indemnity Coverage without an expense incurred inpatient hospital component, thus requiring an 8.18% surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds.
 - HMO non-Medicaid managed care coverage, thus requiring an 8.18% surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident non-Medicaid insureds.
 - HMO Medicaid managed care coverage, thus requiring an 5.98% surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident Medicaid insureds.
 - New York State Workers Compensation Law coverage, thus requiring an 8.18% surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds.
 - New York State Motor Vehicles Reparations Act coverage, thus requiring an 8.18% surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds.
 - New York State Volunteer Ambulance Workers Benefit Law coverage, thus requiring an 8.18% surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds.
 - New York State Volunteer Firefighters Benefit Law coverage, thus requiring an 8.18% surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds.
- HMO or other type of insurer, other than self-insured fund, organized and operating under OTHER THAN New York State Insurance and Public Health Laws, thus requiring an 8.18 percent surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds.

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Self insured fund offering:

- self insured employee health coverage with an expense incurred inpatient hospital component, thus requiring an 8.18% surcharge obligation on affected services plus regional GME covered lives assessments for NYS resident
- self insured employee without an expense incurred inpatient hospital component, thus requiring an 8.18% surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident plan participants.
- self insured New York State Workers Compensation Law coverage, thus requiring an 8.18% surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident plan participants.
- self insured non-New York State Workers Compensation Law coverage, thus requiring an 8.18% surcharge obligation on affected services and a regional GME covered lives assessments for NYS resident plan participants.
- self insured New York State Motor Vehicles Reparations Act coverage, thus requiring an 8.18% surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds.
- self insured non-New York State Motor Vehicles Reparations Act coverage, thus requiring an 8.18% surcharge obligation on affected services and a regional GME covered lives assessments (if coverage includes expense incurred inpatient hospital care) for NYS resident plan participants.
- New York State political subdivision for local corrections, thus requiring an 5.98% surcharge obligation on affected services but no regional GME covered lives assessment on correctional inmates.
- States other than New York State and localities other than New York State political subdivisions for medical assistance program expenses, thus requiring an 8.18% surcharge obligation on affected services but no regional GME covered lives assessment.
- NYS licensed fraternal benefit societies offering:
 - coverage with an expense incurred inpatient hospital component, thus requiring an 8.18% surcharge obligation on affected services.
 - coverage without an expense incurred inpatient hospital component, thus requiring an 8.18% surcharge obligation on affected services but no regional GME covered lives assessments for NYS resident insureds.

ATTACHMENT 2.2 REPORT OF NUMBER OF COVERED LIVES

PAYER NAME:

FEDERAL ID #

TPA NAME:

TPA FEDERAL ID#:

1. Enter the total number of covered lives, before apportionment.

	REGION							
	NEW YORK CITY	LONG ISLAND	NORTHERN METRO	NORTH-EASTERN	UTICA/WATERTOWN	CENTRAL	ROCHESTER	WESTERN
(A) INDIVIDUAL								
(B) #FAMILY								

For the total number of covered lives reported above, enter the number of covered lives subject to apportionment between/among insureds, the percentage of assessment total which you will be paying on the number of apportioned lives, and the resultant product.

	REGION							
	NEW YORK CITY	LONG ISLAND	NORTHERN METRO	NORTH-EASTERN	UTICA/WATERTOWN	CENTRAL	ROCHESTER	WESTERN
(C) INDIVIDUAL SUBJECT TO APPOINTMENT								
(D) APPOINTMENT PERCENTAGE								
(E) APPOINTMENT # OF INDIVIDUAL COVERED LIVES								
(F) #FAMILY SUBJECT TO APPOINTMENT								
(G) APPOINTMENT PERCENTAGE								
(H) APPOINTMENT # OF FAMILY COVERED LIVES								

Enter the number of not covered lives (to the nearest tenth) after apportionment.

	REGION							
	NEW YORK CITY	LONG ISLAND	NORTHERN METRO	NORTH-EASTERN	UTICA/WATERTOWN	CENTRAL	ROCHESTER	WESTERN
(A-C) +E								
(B-F) +H								

ATTACHMENT 2.3

SUMMARY OF APPORTIONMENT ARRANGEMENTS

ORGANIZATION
NAME:FEDERAL TAX
IDENTIFICATION #:TPA/ASO
NAME:TPA/ASO FEDERAL
TAX IDENTIFICATION #:

For every other payor listed below, a copy of the apportionment agreement must be attached. If additional space is needed, please photocopy this form and renumber the first column.

NO.	NAME OF OTHER PAYOR	FEDERAL TAX IDENTIFICATION #	NUMBER OF INDIVIDUAL COVERED LIVES SUBJECT TO APPORTIONMENT	NUMBER OF FAMILY COVERED LIVES SUBJECT TO APPORTIONMENT
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
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19				
20				

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ATTACHMENT 2.6

PUBLIC GOODS SURCHARGE/COVERED LIVES
ELECTION FORM

CHANGE OF THIRD PARTY ADMINISTRATOR (TPA) STATUS for PAYORS

If an electing payor changes their third party administrator (TPA) or administrative services only organization (ASO), the form below must be completed and submitted to the Department's pool administrator. NOTE: This form is only to be utilized by payors, not TPAs. TPAs should file Attachment #2.4-A or #2.4-B Addendum.

Effective Date:

Fill out all applicable information.

PAYOR INFORMATION:

FEDERAL EMPLOYER
IDENTIFICATION # (EIN):

NAME:

PREVIOUS TPA/ASO INFORMATION:

FEDERAL EMPLOYER
IDENTIFICATION # (EIN):

NAME:

PRESENT (NEW) TPA/ASO INFORMATION:

FEDERAL EMPLOYER
IDENTIFICATION # (EIN):

NAME:

ADDRESS:

CONTACT PERSON:

PHONE #:

Signature of Payor _____

Date _____